A HIGH INTENSITY USER SERVICE FOR INDIVIDUALS WITH COMPLEX NEEDS IN NCL

Working with Non-Clinical Care Coordinators in Enfield and Haringey tackling health inequalities

AT A GLANCE

- **Project aim:** To tackle health inequalities through promoting **integrated working with teams** across hospital, community, primary care and mental health services, London Ambulance Service, Local Authority (LA) & VCS organisations in Enfield and Haringey.
- **Cohort:** High intensity users (HIU) who attend the emergency department in North Middlesex University Hospital **more than 15 times a year or more than 5 times a month**, and who often have complex needs.
- **Personalised Care Team:** Non-clinical Care Coordinators (CC) with a third party contract based in Mind (two CC based in Haringey and two CC based in Enfield).
- **Referral:** Informatics Team in hospital send a report of patients frequently attending the emergency department to the team to triage & identify appropriate patients.
- **Who:** North Middlesex University Hospital NHS Trust in collaboration with Mind in Haringey, and Mind in Enfield.

FUNDING

- Funded by NCL ICS for a one year pilot between January 2022 and January 2023, and renewed for another year until 2024.
- Third party contract with Mind funding CC roles.

LEAD: Melanie Oghene, High Intensity User Lead, North Middlesex University Hospital NHS Trust.

IMPACT

- Increased wellbeing **by 20-25%** (**Warwick Mental Well-being Scale)**
- 30% reduction rate in ED attendances (400 reduced attendances to ED within a five month period)

THE CHALLENGE

- HIU or frequent attenders of emergency departments often have **complex needs and multiple disadvantages**, exacerbated by wider social determinants of health.
- Use of different systems across the boroughs in NCL makes **sharing patient data** between primary & secondary care a challenge.

THE ACTION PLAN

- Team based in North Middlesex University Hospital receive report of patients over attendance threshold **(120 top high intensity users of A&E identified utilising A&E data systems)** then triage to identify patients who would benefit from support.
- **Personalised person-centred approach** focusing on the individual's issues, identifying, de-medicalising, de-criminalising and humanising their needs to uncover the core reasons for attending A&E or an admission.
- Where **beneficial to patient**s, they are linked with a CC who meets with patients to identify unmet needs.
- Use **Urgent Care Plan (UPC)**, a system to create bespoke care plans for the HIU cohort that can be shared with NHS professionals for continuity of care.
- After **12 weeks** on the programme, patients are discharged into community or voluntary support services.
- CC come into hospital one day per week to engage with hospital staff & raise awareness of the role. They also hold an HIU day once per month taking a **multidisciplinary approach to promote the service** including a stall in the hospital foyer.
- CC are **directly employed by Mind** but line managed by a Project Manager on the pilot, and meet fortnightly. Training in UPC, basic training and induction are led at the hospital.

NEXT STEPS

- Building **relationships with local services** in neighbouring boroughs & **growing the CC team** to have an allocated person in each NCL borough to bring consistent & appropriate care.
- Focusing on utilising the most appropriate support in local communities and encouraging use of UPC as a shared system.
- Project has been **renewed for another year until 2024**.